Different Like Me, Inc.

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1200 NW 17th Avenue, Delray Beach, FL 33486
Phone (561) 270-2280

Consent for Treatment

I, _____ give consent for treatment for my child _____. I have been informed of the nature and purpose of evaluation and/or treatment.

I understand that during treatment, the above-named, patient, a minor will disclose confidential information about himself/herself that is crucial to the therapeutic process and for which the client has asked Different Like Me Inc. staff to maintain his/her confidence. I agree that Different Like Me Inc. staff will not disclose to the legal guardian such information unless the child is at risk of harming himself/herself or others, or it is otherwise clinically, ethically and or legally appropriate to make such disclosure to the legal guardian.

I understand that I am responsible to pay for services at the time they are rendered. Different Like Me Inc. does not participate or accept any assignment of medical or mental health benefits other than Medicare.

I have read, understand, and consent to all of the conditions stated above. Furthermore, I assert that I am the legal guardian of the above-named client and that as such, I have the right to client's consent for treatment and that additional signatures are not required.

_____

Parent/Guardian Signature Date

I have witnessed the signature of the legal guardian.

_____

Witness Signature Date

Different Like Me, Inc.

IMPORTANT INFORMATION AND CONSENT FOR TREATMENT

Thank you for choosing this service. This sheet describes some details about our professional relationship. If there is anything you do not understand please ask me and I will be happy to discuss it with you.

Appointments and Fees

Fees for service are payable at the time of each visit, unless other payment arrangements have been established. You are responsible for the annual deductible and any percentage of the fee not covered by your insurance plan. We will gladly fill out any insurance claim forms for you so that *you* can be reimbursed. Your appointment time is reserved just for you. You are responsible for the full fee for all scheduled appointments, and ***will be charged for any canceled appointment unless you notify us at least 24 hours in advance***. There is a $30.00 bank charge fee for any returned check.

Confidentiality

We are committed to protect your privacy and confidentiality to the fullest extent possible in accordance with the Federal Health Insurance Portability and Accountability Act (**HIPAA**) and Florida Laws 491.0147 and 394.459 and Title 42 of the Code of Federal Regulations (chemical abuse/drug addiction).
You will have an opportunity to receive the Notice of Privacy Practices under **HIPAA.**

Communication with clients and clients' communication with his/her therapist is considered privileged communication under the law. No disclosure of information about a client, current or past, may be released to any person or agency without a written consent for release of information properly executed and signed by the client. This rule applies equally to both written and oral communications.

The current state laws and regulations limit confidentiality and require disclosure under the following circumstances: (1) A receipt of a valid court order. (2) If there is any suspicion of physical, sexual, or emotional abuse and/or neglect of a child, we are required by law to inform the Florida Department for Families and Children. We are also required by law to inform Adult Protective Services, Department of Elder Affairs, if there is any suspicion of physical abuse of a dependent adult. (3) If we have a reasonable cause to believe that you are a danger to yourself or to the person or property of someone else, then disclosure must be made to an appropriate individual or agency that can prevent the threatened danger. The written case record is kept for seven years and is then destroyed by shredding.

Insurance Assignment and Consent for Treatment

By signing below you are authorizing the release of any necessary information about your case to your primary and, if applicable, secondary insurance or Medigap company to process your insurance claim. You are also assigning benefits to Different Like Me, Inc. for any eligible payments from any insurance carrier, including Medicare and Medigap. This is a direct assignment of the rights and benefits under the insurance policy. You agree to pay any balance due over insurance payments. You understand that you do not need to provide your supplemental insurer with information concerning your Medicare claim, because signing this authorization will cause Medicare payment to cross over automatically. A copy of this assignment shall be considered as effective and valid as the original.

I have read and understand the above, and agree to engage your professional services under these terms and conditions.

*(Print Name)*_____ *DOB:*_____

(Signature)_____ *Date:* ____/____/____

Different Like Me, Inc.
Authorization For Disclosure

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____, authorize Different Like Me, Inc. to disclose to and/or obtain from:

_____

_____

_____ the following information:
[Insert Name of Person or Title of Person or Organization and contact phone or address]

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Neuropsychological Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____ Speech/Cognitive Therapy Notes
(Evaluations, TX, and Progress Notes)

_____ Therapy and Treatment Notes
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes*
*(*Cannot be combined with any other disclosure)*
_____ Summary of notes
_____ Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than stated above, please specify:

_____

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Different Like Me, Inc. at 1200 NW 17th Ave. Suite 12, Delray Beach, FL 33445. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date 1 year or as otherwise indicated:_____

Conditions

I further understand that Different Like Me, Inc. will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: Unable to release records

_____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

_____

(Parent, Guardian or Personal Representative Name if not signed by patient)

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____

Signature of Staff Witness Date

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Failure to Cancel/ No Show

Patients Name: _____ Date of Birth: _____

I understand that if I fail to attend a scheduled appointment, and fail to cancel the appointment within one full business day prior to the scheduled appointment, I will be responsible for the full fee for all scheduled appointments. Insurance will not reimburse me for this expense nor will Different Like Me Inc bill my insurance for this expense.

I hereby agree to pay the no-show fee as set forth above.

_____

Signature of Patient Date

_____

Signature or Parent, Guardian or Personal Representative * Date

_____

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

Witness' Signature: _____

1200 NW 17th Avenue, Suite 12, Delray Beach, FL 33445 Phone: (561) 270-2280 Fax: (561) 270-2284
E-Mail: alysenovember@differentlikeme.com Web: www.differentlikeme.com

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PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name_____ Date of Birth: _____

Please indicate how you would like staff from Different Like Me, Inc. to contact you. Unless specified below, we will attempt to make contact utilizing any information you have provided to us. Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection except if an emergency arises.

Please contact me as indicated below:

Cell# _____Home # _____

Work # _____ Email: _____

Mail/Address: _____

_____

_____**You may leave a message on any phone number listed above**

_____You may leave a message with (Names) _____

_____ _____

Signature of Patient or Legal guardian Date

_____

Name of legal guardian signing this form if other than patient

Approved: _____ _____

Signature of Staff Date

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